STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155793	B. WIN			01/16/2	2013
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC			RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This survey wa	s for a Recertification	F00	00	February 8, 2013 Kim Rhoade	es,	
	and State Licensure Survey.				Director Long-Term Care Division		
		•			Indiana State Department of		
	Survey dates:	January 7, 8, 9, 10,			Health 2 North Meridian Street	t	
	11, 14, 15 & 16	•			Indianapolis, IN 46204 Re:		
	11, 1 4 , 15 00 10	,, 2010.			Allegation of Compliance Dea Ms. Rhoades: Please find	ur	
	F==:::::::::::::::::::::::::::::::::::	040044			enclosed the Plan of Correction	n to	
	Facility number				the annual Recertification and	11 10	
	Provider numb				State Licensure Survey		
	AIM number: 2	201046710			conducted on January 16, 201	3.	
					This letter is to inform you that		
	Survey team:				plan of correction attached is t	0	
	Christi Davidso	n, RN-TC			serve as Hamilton Trace's		
	Janet Stanton,	-			credible allegation of complian	ice.	
	Michelle Hoste				We allege compliance on		
	Who holle i loote	(C), 1 (1)			February 15, 2013. We are	.:.	
	Canaua had tur	201			requesting a desk review for the plan of correction. I If you have		
	Census bed typ	Je.			any further questions, please of		
	SNF: 36				not hesitate to contact me at		
	SNF/NF: 64				(317) 813-4444. Sincerely,		
	Residential: 32	2			Melissa Hampton, HFA		
	Total: 132				Administrator Submission of	this	
					plan of correction in no way		
	Census payor t	type:			constitutes an admission by		
	Medicare: 33	J.			Hamilton Trace of Fishers or it		
	Medicaid: 36				management company that the	e	
	Other: 63				allegations contained in the survey report is a true and		
					accurate portrayal of the provi	sion	
	Total: 132				of nursing care or other service		
					provided in this facility. The Pla		
	Residential sar	npie: 8			of Correction is prepared and		
					executed solely because it is		
	These deficiend	cies reflect state			required by Federal and State		
	findings cited in	n accordance with 410			Law. The Plan of Correction is		
	IAC 16.2.				submitted in order to respond		
					the allegation of noncompliand	ce	
					cited during the Annual		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

012644

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155793	B. WING		01/16/2013
	PROVIDER OR SUPPLIE ON TRACE OF FIS		11851	ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review	v completed on January trenda Meredith, R.N.		Recertification and State Licensure Survey on January 2013. Please accept this plan correction as Hamilton Trace of Fisher's credible allegation of compliance by February 15, 2 This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	16, of of 013.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 2 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	COMI	E SURVEY PLETED	
		155793	B. WING			6/2013
	PROVIDER OR SUPPLIER		11851	TADDRESS, CITY, STATE, ZIP C I CUMBERLAND RD ERS, IN 46037	CODE	
(X4) ID PREFIX TAG F0156 SS=C	(EACH DEFICIEN REGULATORY OR 483.10(b)(5) - (10 NOTICE OF RIGI CHARGES The facility must i orally and in writin resident understa all rules and regu	HTS, RULES, SERVICES, Inform the resident both Ing in a language that the Inds of his or her rights and Ilations governing resident	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	in the facility. The the resident with State developed of Act. Such notification or upon admission stay. Receipt of s	onsibilities during the stay e facility must also provide the notice (if any) of the under §1919(e)(6) of the ation must be made prior to n and during the resident's such information, and any , must be acknowledged in				
	entitled to Medicathe time of admissor, when the resident included in nursing State plan and for not be charged; the resident may amount of charge inform each resident made to the items.	nform each resident who is a side benefits, in writing, at sion to the nursing facility dent becomes eligible for the ems and services that are gracility services under the end which the resident may nose other items and facility offers and for which the charged, and the soft for those services; and the end when changes are so and services specified in the end with the end of the en				
	before, or at the t periodically during services available charges for those charges for servic Medicare or by th	inform each resident ime of admission, and g the resident's stay, of a in the facility and of services, including any each of covered under e facility's per diem rate.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 3 of 76

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	00	COMPL	ETED	
		155793	B. WING			01/16/	2013	
			_	REET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIE	₹			UMBERLAND RD			
HAMILTO	ON TRACE OF FIS	HERS LLC			S, IN 46037			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREF		CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LISC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE	
	•	he manner of protecting under paragraph (c) of this						
	procedures for example Medicaid, including assessment under determines the example resources which available for payinstitutionalized significant and the second of the se	the requirements and stablishing eligibility for ng the right to request an er section 1924(c) which extent of a couple's curces at the time of an and attributes to the se an equitable share of cannot be considered ment toward the cost of the spouse's medical care in his spending down to the stable share of the spending down to the spending down to the stable share of the spending down to the spending down to the stable share of the spending down to the stable share of the spending down to the stable share of the stable						
	telephone number client advocacy of survey and certificensure office, to program, the program, the program, and the and a statement complaint with the certification agent abuse, neglect, a resident property	es, addresses, and ers of all pertinent State groups such as the State dication agency, the State the State ombudsman tection and advocacy Medicaid fraud control unit; that the resident may file a e State survey and acy concerning resident and misappropriation of in the facility, and with the advance directives						
	489 of this chapt written policies a advance directive include provision written informatic concerning the ri	comply with the ecified in subpart I of part er related to maintaining and procedures regarding es. These requirements is to inform and provide on to all adult residents ght to accept or refuse all treatment and, at the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 4 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	(3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	8			CUMBERLAND RD		
HAMII TO	ON TRACE OF FIS	HERSLIC			RS, IN 46037		
					I		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICILIACI)		DATE
		n, formulate an advance					
	directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.						
	The facility must	inform each resident of the					
		and way of contacting the					
	physician respon	sible for his or her care.					
	The feetility and the	managina authoralia alianda e e de alianda e					
		prominently display in the ormation, and provide to					
	1	plicants for admission oral					
	I	nation about how to apply					
		care and Medicaid benefits,					
		ve refunds for previous					
	payments covere	ed by such benefits.					
	Based on obse	ervation, record review	F01	56	F156 I. The corrective		02/15/2013
	and interview,	the facility failed to			actions to be accomplished	or	
	prominently dis	splay, in an area readily			those residents found to hav	-	
	l · •	I frequented by most			been affected by the deficien		
		en information related			practice. The State advoca	су	
	to Resident Ri				groups addresses and phone		
	· ·	-			numbers were posted in the model lobby. Residents #134, #37		
		ses/phone numbers of			and family member of residen		
	·	ate advocacy groups,			#47 were notified of the location		
		ormation about			of the Resident Rights posting		
		se of Medicare and			State advocacy groups posting		
		fits. This deficiency			and information about applying	9	
		ial to affect 100 of 100			and use of Medicare and		
	residents resid	ing in the certified			Medicaid benefits displayed in		
	nursing facility	area.			community. II. The facility	′	
					will identify other residents that may potentially be affect	ted	
	Findings include	le:			by the deficient practice.	.cu	
					Resident's residing in the facil	itv	
	The initial obse	ervation tour was			had the potential to be affected	•	
		1/7/13, beginning at			III. The facility will put into		
		the 300-400 Wing,			place the following systemat	ic	
		•			changes to ensure that the		
		800 Wing, and			deficient practice does not		
	500/Aizheimer	's secured locked unit.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 5 of 76

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155793		LDING		01/16/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
1 1 A B A 11 T C		IEDO I I O			CUMBERLAND RD		
HAMILIC	ON TRACE OF FISI	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Signs related to	o Resident Rights,			recur. A copy of the require		
	State advocacy	y groups, or			information of the following ha	S	
	Medicare/Medi	caid application and			been posted: resident rights,		
		ocated on any of the			names, addresses and telephonumbers of all pertinent State	one	
	units.	,			client advocacy groups, the		
	di inco.				Medicaid Fraud control unit, a	nd	
	ON 1/7/13 at 1	1:30 A M an			a statement regarding how to		
		as done in the front			apply for and use Medicare an	ıd	
					Medicaid benefits, and how to		
	1	ain facility entrance.			receive funds. Residents and		
	No Resident R	•			families will be educated upon		
		caid information, and			admission where this informati can be located. In addition, ea		
	no advocacy p	hone numbers were			unit has a posting detailing the		
	found.				location of these documents	•	
					within the facility. IV The		
	On 1/7/13 at 1:	:26 P.M., the front			facility will monitor the		
		erved again. An 8 by			corrective action by		
		of paper with the State			implementing the following		
		esses and phone			measures. The postings wil	I	
	1	observed in a clear			be reviewed monthly for 6 mor	nths	
					to ensure compliance.		
	l •	ent holder, placed at the			Location of resident rights, sta		
		table just inside the			advocacy groups and applying and use of Medicare and	l	
		the lobby. A paper			Medicaid will be reviewed in		
		t Rights for Housing			resident council monthly 3		
	with Services E	Establishment" was			months then quarterly thereaft	er	
	located in a fra	me, and hanging on			for a total of 12 months.		
	the wall in a sh	ort hallway between			Results of this audit will be		
	the front lobby	and a cross-hallway to			reviewed at the monthly Qualit		
	the nursing uni	•			Assurance Committee meeting		
		using rights" rather			and frequency and duration of		
		Rights as required and			reviews will be adjusted as needed. V. Plan of		
		deral regulation.			Correction completion date.		
		derai regulation.			Plan of Completion date is		
	Description on the second of				February 15, 2013.		
	•	y conference on					
	1/11/13 at 4:45	·					
	Administrator a	and Consultant Nurse					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 6 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	(X3) DATE COMPL	
THIND I LIMIT	or conduction	155793		LDING		01/16/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0 0.	
NAME OF F	PROVIDER OR SUPPLIER				CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC			RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION DATE
TAG		*		TAG			DATE
		gency phone numbers stic holder on the table,					
	•	nt the paper posted for					
	_	ts" was the correct					
	one.	to was the confect					
	01.0.						
	In an interview	on 1/14/13 at 11:19					
		#134 indicated she					
	· ·	ny signs for agencies,					
	resident rights,	or Medicare. She					
	indicated she o	nce had a booklet on					
	Resident Right	s, but does not have it					
		did not know where					
		e information could be					
	•	n the facility. She					
		vas able to get around					
	•	g her wheelchair, but					
	did not go to th	e front lobby.					
	In an interview	on 1/14/13 at 11:27					
	A.M., Resident	#37 indicated she had					
		id not know where any					
		formation could be					
	•	n the facility. She					
		vas able to get around					
		g her wheelchair, but					
	did not go to th	e tront lobby.					
	In an interview	on 1/14/13 at 11:34					
		nember for Resident					
		she had gotten a					
		ident Rights, but had					
		igns posted on that or					
		nation, and did not					
	know where it i	might be located.					
							ı

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 7 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM 01/1	e survey pleted 6/2013
	PROVIDER OR SUPPLIER ON TRACE OF FISHERS LLC	11851 (ADDRESS, CITY, STATE, ZIP CO CUMBERLAND RD RS, IN 46037	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3.1-4(a) 3.1-4(j)(3) 3.1-4(l)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 8 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155793	A. BUII B. WIN			01/16/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CUMBERLAND RD		
нами тс	N TRACE OF FISH	HEDS II C			RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0167 SS=C	ACCESSIBLE	YEY RESULTS - READILY					
		e right to examine the					
		st recent survey of the					
		by Federal or State y plan of correction in					
	effect with respec						
	enect with respec	t to the facility.					
	The facility must i	make the results available					
		nd must post in a place					
	readily accessible	e to residents and must					
	post a notice of the	neir availability.					
	Based on observation and interview,		F01	67			02/15/2013
	the facility faile	d to prominently			F167		
	display and pos	st a notice of their					
		n area frequented by					
	•	, the results of the					
		rvey conducted by			I. The corrective actions t	0	
		•			be accomplished for those	•	
		e surveyors, and any			residents found to have		
	•	on. This deficiency			been affected by the		
	•	al to affect 100 of 100			deficient practice.		
	residents resid	ing in the certified					
	nursing facility	area.					
	Findings includ	e:			The survey results binder w displayed in the front lobby	as	
	The initial obse	ervation tour was			beside the main entrance in	1	
		1/7/13, beginning at			the community. Residents		
		the 300-400 Wing,			#134, #37 and family memb	er	
	·	•			of resident #47 were notified	d	
	_	800 Wing, and			of the location of the survey	•	
		s secured locked unit.			results.		
	•	o the location of the					
	•	were not located on					
	any of the units	S.					
	On 1/7/13 at 1	1: 30 A.M., an			II. The facility will identify	1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 9 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLI	ETED
		155793	B. WIN			01/16/	2013
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CUMBERLAND RD		
HAMILTO	ON TRACE OF FIS	HERS LLC			RS, IN 46037		
					I		~~~
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG				IAU	· ·		DATE
		as done in the front			other residents that may		
	lobby at the main facility entrance. No survey results or sign on location				potentially be affected by		
					the deficient practice.		
	was found.						
	On 1/7/13 at 1	:26 P.M., the front			Resident's residing in the		
	lobby was obs	erved again. A survey			facility had the potential to	he	
	book/binder wa	as located on front			affected.		
	table at front o	f building next to main					
		The title was facing					
		main traffic pattern.					
		mani damo panomi					
	During the dail	y conference on					
	1/11/13 at 4:45	-			III The facility will put into	0	
		and Consultant Nurse			place the following		
					systematic changes to		
		urvey book was located			ensure that the deficient		
		the front lobby and			practice does not recur.		
	was easily acc	essible to all residents.					
	In an interview	on 1/14/13 at 11:19				_	
	A.M., Residen	t #134 indicated she did			All new admissions and the		
	not know wher	e the survey book			families will be educated up		
	could be found	l, and had not seen any			admission on how to locate		
	signs posted in	n the facility on its			the survey results. In additi	on,	
	1 5 '	indicated she was able			each unit has a posting		
		the facility using her			detailing the location of the		
	_	t did not go to the front			survey results within the		
	lobby.	t did not go to the nont			facility.		
	1000y.						
	In an interview	on 1/14/12 of 11:27					
		on 1/14/13 at 11:27					
	· ·	t #37 indicated she did					
		e the survey book was,			IV The facility will monit	or	
		he could ask someone			the corrective action by		
	and they would	d tell where it was. She			implementing the following	, l	
	indicated she	was able to get around			insponding the following	.a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 10 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE S COMPL 01/16/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the facility usin did not go to th	g her wheelchair, but e front lobby.			measures.		
	A.M., a family r #47 indicated s	on 1/14/13 at 11:34 member for Resident she had not seen the ad had not seen any its location.			The posting will be reviewed monthly for 6 months to ensure compliance.	ed	
	3.1-3(b)(1)				Location of survey results binder will be reviewed in resident council monthly 3 months then quarterly thereafter for a total of 12 months.		
					Results of this audit will be reviewed at the monthly Quality Assurance Commit meeting and frequency and duration of reviews will be adjusted as needed.	tee	
					V. Plan of Correction completion date. Plan of Completion date is February 15, 2013.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 11 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155793	B. WING		01/16/2013
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			CUMBERLAND RD	
HAMILTO	ON TRACE OF FISH	HERS LLC		RS, IN 46037	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0279 SS=D	483.20(d), 483.20 DEVELOP COMF)(k)(1) PREHENSIVE CARE			
	PLANS				
	•	e the results of the			
		evelop, review and revise			
	the resident's con	nprehensive plan of care.			
		develop a comprehensive			
		n resident that includes			
	•	ctives and timetables to			
		medical, nursing, and			
		nosocial needs that are			
	identified in the co	omprehensive assessment.			
	The care plan mu	st describe the services			
	that are to be furr	nished to attain or maintain			
	the resident's higl	hest practicable physical,			
		hosocial well-being as			
		183.25; and any services			
		vise be required under			
	_	not provided due to the			
		e of rights under §483.10, t to refuse treatment under			
	§483.10(b)(4).	to refuse treatment under			
		view and record	F0279	F279 I. The corrective	02/15/2013
	review, the faci	ility failed to develop		actions to be accomplished	for
		dressing range of		those residents found to have	re
	motion services	• •		been affected by the deficier	
		or 1 resident who had		practice. The care plans fo	
				resident #81 have been updat	ed
		nd stayed in bed		to reflect appropriate	
	,	; and addressing		interventions. The care plan f	
	_	site services for 1		resident #74 has been update reflect appropriate intervention	
		ad a hemodialysis		II. The facility will identif	
	shunt access s	ite (Resident #74); in a		other residents that may	'
	sample of 29 re	esidents reviewed for		potentially be affected by the	•
	Care Plans.			deficient practice. Current	
				residents with contractures or	
	Findings includ	le·		receiving dialysis could potent	tially
				be affected. Care Plans for	
				residents with contractures or	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 12 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155793	B. WIN			01/16/2013
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				CUMBERLAND RD	
HAMII TO	ON TRACE OF FISH	HERSIIC			RS, IN 46037	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		IAG		5.112
		record for Resident			receiving dialysis were reviewed and updated as needed to	eu
	#81 was reviewed on 1/15/13 at 9:50				determine that appropriate	
		es included, but were			interventions were present.	
	not limited to, S	Stage 4 Pressure Ulcer,			III. The facility will put into	
	paraplegia, mu	scle weakness,			place the following systemat	ic
	cognitive impai	rment, colostomy, joint			changes to ensure that the	
	contractures, a	nemia, narcolepsy,			deficient practice does not	
		ogenic bladder, chronic			recur. Staff were re-educate	ed
	kidney disease	_			on the development of	
	1	order, atrial fibrillation,			comprehensive care plans.	
		ikemia in remission.			Facility will have an outside provider review Activity care p	ans
		ikeriia iii remission.			of residents with contractures	ans
	A la an intervi	and 1/0/12 at 10:25			quarterly for one year to ensur	e l
		ew on 1/9/13 at 10:35			compliance. Nurses have be	
		3 indicated the resident			provided education on the	
		g contractures, and			requirement to update the care	•
	was not curren	tly receiving any			plan for any residents who	
	therapy, restora	ative care, or routine			develop contractures, begin	
	range of motior	n exercises. She was			dialysis and/or when the intervention in place needs to	he
	unsure if he ha	d any splints or			changed for more appropriate	oe
	devices, and in	dicated she would call			care and treatment of a reside	nt.
	a family memb	er. Later, L.P.N. #3			IV The facility will monitor	
		mily member indicated			the corrective action by	
		d splints at home, and			implementing the following	
		em in to have the			measures. The DON/design	
	Physical Thera				will review care plans of reside	
	1	and the resident for			with contractures and/or residence receiving dialysis monthly for 3	
		and the resident for			months and then quarterly	
	needs.				thereafter for a total of 12	
		450 B41 1 5 1			months. Facility will have ar	1
		MDS [Minimum Data			outside provider review Activity	
		nt, dated 7/25/12,			care plans of residents with	
	indicated the re	esident had a BIMS			contractures quarterly for one	
	[Brief Interview	for Mental Status]			year to ensure compliance.	
	score of "12" [8-12=moderately				Results of the reviews will be presented at the monthly Qual	ity
	impaired]; and	lower extremity			Assurance Committee meeting	•
	impairment of b	•			and frequency and duration of	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 13 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN			01/16/	2013
NAME OF I	DOLUBED OD GUDDUE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIE	K		11851 0	CUMBERLAND RD		
HAMILTO	ON TRACE OF FIS	HERS LLC		FISHER	RS, IN 46037		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the rindependent recarehe was a and reasonable bilateral impair extremities. A 7/10/12, "Action of the rindependent recars and reasonable bilateral impair extremities."	egarding tasks of daily able to make consistent e decisions; and had rment of the lower			reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is February 15, 2013.		
	had no functio motion] impair extremities; ha bilateral lower	ndicated the resident nal ROM [range of ment of the upper ad impairment of the extremities with the chest down, and no					
	Physical Thera Discharge Sur "Exhibits bilate flexed position	ate care hospital apy Progress and ammary indicated eral lower extremity in bed. Tolerates extremity stretching in					
	A Care Plan a contractures w	<u> </u>					
	gave an order Therapy] to ev contracture ma 1/8/13, Physic	attending physician for "P.T. [Physical valuate and treat for anagement." On al Therapy wrote an evaluation completed					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED 01/16/2013		
		155793	B. WIN	G		01/16/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HAMILTO	ON TRACE OF FISH	HERS LLC			CUMBERLAND RD RS, IN 46037		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
	this date. To be	e seen 5 times/week,					
	for 2 weeks for	contracture					
	management.						
	In an interview	on 1/15/13 at 11:58					
	A.M., the Physi	cal Therapy					
	Department Ma	anager indicated she					
	had spoken wit	h his therapist, who					
	saw resident in	July, 2012, after his					
	admission, unti	l 8/31/12. She and the					
	resident's thera	pist did not know					
	anything about	a splint from that time.					
	She indicated v	vhen she went the end					
	of last week to	look, the splint was in					
	the closet. The	resident told her the					
	splint was from	another facility and					
	never fit; he wo	ould not wear it. The					
	P.T. Manager ii	ndicated Nursing staff					
	usually provide	d routine ROM					
	exercises when	needed. She					
	indicated she h	ad no other					
	information at t	hat time, but would					
	look for any Ca	re Plan or other					
	documentation	regarding splints or					
	PROM [passive	e range of motion]	1				
	provided. At th	at time, she provided	1				
	an electronic he	ealth record report,					
	titled "PTTher	apist Progress &	1				
	Discharge Sum	mary," dated 8/31/12.	1				
	The report indic	cated the resident the					
	resident receive	ed "skilled training and					
	education on th	erapeutic exercises					
	and wheelchair	mobility which allowed					
	transition of car	re from therapy to the	1				
	patient and care	egiver." The residents					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 15 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			CUMBERLAND RD		
HAMILTO	ON TRACE OF FISI	HERS LLC			RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"current" level						
		as "The patient					
	exhibits bilater	al lower extremity					
	flexed position in bed. Patient						
	tolerates bilate	ral lower extremity					
	stretching in al	l planes." There was					
	no documentat	tion related to use of					
	splints or provi	sion of ROM exercises.					
	In an interview	on 1/16/13 at 10:00					
	A.M., Resident	t #81 indicated the					
	· ·	ad not been doing any					
		es on his legs until the					
		ek. He said "It really					
	feels good."	in the cara in really					
	l looio good.						
	B In an interv	iew on 1/9/13 at 10:16					
		#81 indicated he had					
	· ·	ved with any of the					
		s due to the pressure					
		ttom, but had plenty to					
		• •					
		at this point in time. He					
		ad been "pretty much					
	, , ,	" but the sore was					
		so he would be getting					
	•	ndicated he will explore					
		ties as he becomes					
		nd up for longer					
	periods of time).					
		epartment progress					
	•	l3/12, indicated "As					
		s to acclimate to					
	transition to ne	w facility, Act. staff will					
	invite and enco	ourage to attend					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 16 of 76

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/16/2013	
	PROVIDER OR SUPPLIER		B. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DECLIPED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
		erest." There were no rogress notes found.					
	The Admission 7/25/12, indica to the resident have family invidecisions, use have his belong "Somewhat impooks/magazir listen to music, animals/pets, to do his favori outside to get for the control of the control of the current intervices assessments in liked board gar cooking, current movies [type no games [kind no music/radio [king "Focus of [Activity of the cous of [Activity of the current intervices].	M.D.S., dated ted it was "Important" to choose his bedtime, olved with care phone in private, and gings locked up. It was portant" for him to have nes/newspapers, to to be around to keep up with news, te activity, and to get fresh air. 11:58 A.M., the Activity ed copies of the th record entries for sment" with dates of 1/31/12. The rms listed the residents by [demographics]; ew on the level of his preferences, and rests. The indicated the resident mes [kind not listed], int events, dining out, ot listed], outdoor					
		pendent Activities; timulating Activities;					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 17 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC			RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Activities; Relig	d Activities; Relaxation gious Activities; Social ivities; Talk-Oriented					
	addressed "He remained stabl affected capac activities. The listed as: "Rely communication"	entry, dated 8/12/12, ealth status has not le and has widely lity for participation in "Approaches" were on coordinated in with nursing to hal combination of s."					
	found addressi	other Care Plan entrying activity or this resident.					
	A.M., L.P.N. #2 [#74] has a shu We have to che	iew on 1/11/13 at 9:40 2 stated "Resident unt in her right arm. eck the bruit/thrill. She perma-cath, but it omething."					
	was reviewed of P.M. Diagnose not limited to, edisease, dysph breath, depress total occlusion	cord for Resident #74 on 1/14/13 AT 1:12 es included, but were end-stage renal nagia, shortness of sive disorder, chronic coronary artery with ain, and diabetes.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 18 of 76

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN	IG		01/16/	2013
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE		
		UEDO LLO			CUMBERLAND RD		
HAMILIC	ON TRACE OF FISI	HERS LLC		FISHER	RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		M.D.S. [Minimum Data					
		7/12, indicated the					
	resident had a BIMS [Brief Interview for Mental Status] score of 15						
	ı -	vely intact], and					
		sis. A Quarterly					
		11/4/12, indicated the					
	same.						
	One Care Diag	datad 0/10/10					
		n, dated 8/10/12,					
		issue of "Resident has					
		I to renal failure." The were listed as "Notify					
		cerns; Administer					
	1	ordered; Assess for					
		•					
		iet as ordered, monitor ake of food and fluids;					
		and output; monitor					
		otify M.D. and family of					
	significant weight						
	Significant weig	gni change.					
	Thoro was no	Care Plan addressing					
		lysis access site,					
		atency of the shunt,					
	1	ocedures in case of					
	, , ,	the site, or not using					
		ne shunt for blood					
		lood test draws.					
	piessuies of b	เบบน เธอเ นเฉพอ.					
	During the dail	y conference on					
	1/11/13 at 4:45	-					
		•					
	Administrator and Director of Nurses were given the opportunity to submit						
	· -	of a Care Plan					
	addressing the	care of the dialysis					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 19 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793			A. BUILDING B. WING	COMPLETED 01/16/2013					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	At the final exit P.M., no addition	d emergency plans. on 1/16/13 at 4:30 onal Care Plan entries on were provided for							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 20 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/16/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CACH CORRECTIVE ACTOR CROSS-REFERENCED TO TAG		ΓE	(X5) COMPLETION DATE
F0318 SS=D	483.25(e)(2) INCREASE/PRENTANGE OF MOTBased on the conaresident, the factoristic increase range prevent further despreyent furt	VENT DECREASE IN ION ION ION ION ION ION ION ION ION I	F03		F318 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #81 was		02/15/2013
	and that neithe extended out s observed at that legs bent at the	Intarily move his legs, r of his legs could be traight. He was at time to have both e knees, and he was m flexed in a crossed nanner.			re-evaluated by therapy and receiving proper range of motion services based on the assessment.		
	A.M., L.P.N. #3 had bilateral le was not curren therapy, restora	on 1/9/13 at 10:35 B indicated the resident g contractures, and tly receiving any ative care, or routine n exercises. She was			II. The facility will identify other residents that may potentially be affected by the deficient practice.	,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 21 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155793	B. WIN			01/16/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹		11851 (CUMBERLAND RD	
HAMILTO	ON TRACE OF FISI	HERS LLC		FISHEF	RS, IN 46037	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DATE
		nd any splints or			Residents who have	
	devices, and indicated she would call				contractures could be affected. Residents with	
	a family member. Later, L.P.N. #3				contractures were assessed	4
	· ·	mily member indicated			for proper treatment and	1
		nd splints at home, and			updated as needed.	
		em in to have the				
		py department				
		and the resident for				
	needs.					
	-	16 D : 1 1 104			III. The facility will put into	
		cord for Resident #81			place the following	,
		on 1/15/13 at 9:50 A.M.			systematic changes to	
	•	uded, but were not			ensure that the deficient	
		je 4 Pressure Ulcer,			practice does not recur.	
		iscle weakness,			practice does not recar.	
		irment, colostomy, joint				
		nemia, narcolepsy,				
		ogenic bladder, chronic			Residents will be screened	for
		e, osteoporosis,			range of motion on a quarte	erly
	! •	order, atrial fibrillation,			basis and as needed. If a	
	and chronic le	ukemia in remission.			resident has shown a declir	ıe
					in range of motion an	
	An Admission	MDS [Minimum Data			appropriate program will be	
		ent, dated 7/25/12,			established.	
	indicated the re	esident had a BIMS				
	[Brief Interview	for Mental Status]				
	score of "12" [8	3-12=moderately			Therapy has been	
	impaired]; and	lower extremity			re-educated on how to	
	impairment of	both sides.			transition residents who have	ve
					been discharged from	
	A Quarterly MI	DS, dated 10/20/12,			treatment. Therapist will tra	ain
	indicated the resident was independent regarding tasks of daily				nursing associates on	
					therapeutic exercises prior	to
	•	able to make consistent			discharge from treatment.	
		e decisions; and had				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155793	B. WIN			01/16/2013
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF I	PROVIDER OR SUPPLIEF	8			CUMBERLAND RD	
HAMILTO	ON TRACE OF FISI	HERS LLC			RS, IN 46037	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	•	ment of the lower				
	extremities.					
	A 7/40/40 "Ad	main ain m Ni main a				
		mission Nursing			IV The facility will monit	or
		ndicated the resident			the corrective action by	
		nal ROM [range of			implementing the following	g
		ment of the upper			measures.	
		d impairment of the				
	bilateral lower extremities with paralysis from the chest down, and no					
					The second Discrete second second	
contractures.					Therapy Director or designed will audit the residents with	
					contractures therapy screen	
		te care hospital			monthly for 3 months then	15
	1	py Progress and			quarterly thereafter for a to	tal
	Discharge Sun	nmary indicated			of 12 months.	
	"Exhibits bilate	ral lower extremity				
		in bed. Tolerates				
	bilateral lower	extremity stretching in				
	all planes."				DON or designee will audit	
					discharge summaries, of	
	A Care Plan ad	ddressing the			residents who remain in the	
	contractures w	as not found.			facility with contractures, fo	
					transition of care and initiat	
	On 1/7/13, the	attending physician			of programs related to rang	
		for "P.T. [Physical			of motion exercises monthly for 3 months then quarterly	
	Therapy] to ev	aluate and treat for			thereafter for a total of 12	
		anagement." On			months.	
		al Therapy wrote an				
		evaluation completed				
		e seen 5 times/week,				
	for 2 weeks for	•			Results of the reviews will be	oe
	management.				presented at the monthly	
	management.				Quality Assurance Commit	
	In an interview	on 1/15/13 at 11:58			meeting and frequency and	
	A.M., the Phys				duration of reviews will be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644 If continuation sheet Page 23 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE COMPL		
		155793	B. WIN			01/16	/2013
	PROVIDER OR SUPPLIER		<u> </u>	11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD		
	ON TRACE OF FISH	HERS LLC		FISHER	RS, IN 46037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	Department Ma	anager indicated she			adjusted as needed.		
	•	th his therapist, who					
	saw resident in	July, 2012, after his					
	admission, unt	il 8/31/12. She and the			V. Plan of Correction		
	resident's thera	apist did not know			completion date.		
	, ,	a splint from that time.			Completion date.		
		when she went the end					
		look, the splint was in					
		e resident told her the			Plan of Completion date is	8	
	•	another facility and			February 15, 2013.		
	,	ould not wear it. The					
	_	ndicated Nursing staff ed routine ROM					
	* *	n needed. She					
	indicated she h						
		that time, but would					
		are Plan or other					
		regarding splints or					
		e range of motion]					
		nat time, she provided					
	an electronic h	ealth record report,					
	titled "PTThe	rapist Progress &					
	Discharge Sun	nmary," dated 8/31/12.					
	•	cated the resident the					
		ed "skilled training and					
		nerapeutic exercises					
		r mobility which allowed					
		re from therapy to the					
	•	regiver." The residents					
	"current" level						
	_	ras "The patient al lower extremity					
		in bed. Patient					
	· · · · · · · · · · · · · · · · · · ·	ral lower extremity					
		I planes." There was					
	<u> </u>	•					<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 24 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

BUILDING WING	00	COMPLETED 01/16/2013
11851 C	CUMBERLAND RD	
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	STREET A 11851 C FISHER ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 25 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	BUILDING 00		COMPLETED	
		155793	B. WIN	G		01/16/	2013
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0332 SS=D	483.25(m)(1) FREE OF MEDIC OF 5% OR MORI The facility must of medication error of greater. Based on observed, ensure it was for rate of five peromedication pass medication pass 58 opportunities observed, resu	cation error rate of sesident #205; R.N. #5]	F03		I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		02/15/2013
	medications we [electronic Medications] Record] to be go at the morning R.N. #5 was obtone tablet of earmedications. According to the on the medicate each of Diltaze	9:00 A.M., nine ere listed in the e-MAR dication Administration given to Resident #205 medication pass. Deserved to dispense ach of prescribed Deserved to be dispensed.			No residents were adversel affected. RN #5 received 1 education regarding correct procedure for medication administration with medicati administration observation to determine compliance. II. The facility will identify other residents that may potentially be affected by the deficient practice.	ion	
	pills.	nould have received 12 ned, R.N. #5 indicated			Residents receiving oral medications could be affect	ed.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 26 of 76

STATEMEN	T OF DEFICIENCIES	ES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155793	B. WIN	G		01/16/	2013
	ROVIDER OR SUPPLIER			11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID mov/m		DROWINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	administered. reviewed the e she just realize dispensed two Diltazem, Vitar B-12. The nurse ther additional table Vitamin D, and	in the cup to be The nurse then -MAR, and indicated ed she should have tablets each of the min D, and Vitamin In dispensed an et for the Diltazem, I Vitamin B-12 before t to the resident.			III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. Licensed nursing staff have been re-educated on appropriate medication administration techniques. IV The facility will monitor the corrective action by		
					the corrective action by implementing the followin measures. Staff Development Coordinator or designee wil audit by observation of medication administration rotating shifts 3 times per week for 4 weeks, then wee for one month, then monthly for a total of 12 months. Ar identified concerns from the audits will be addressed	l ekly y	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 27 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155793	A. BUILDING B. WING	00	COMPLETED 01/16/2013			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE				
	ON TRACE OF FISH		11851 CUMBERLAND RD FISHERS, IN 46037					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				immediately.				
				Results of the reviews will be presented at the monthly Quality Assurance Committed meeting and frequency and duration of reviews will be adjusted as needed.	ee			
				V. Plan of Correction completion date.				
				Plan of Completion date is February 15, 2013.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 28 of 76

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	I		00	COMPL	ETED
		155793	A. BUII			01/16/	2013
		100700	B. WIN			0 17 107	2010
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OF T	NO VIDER OR SOLVER			11851 (CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BELICETY		DATE
F0334	483.25(n)	DNEUMOOOOOM					
SS=E		PNEUMOCOCCAL					
	IMMUNIZATIONS						
		develop policies and					
	procedures that e						
	(i) Before offering						
		ch resident, or the					
		epresentative receives					
	•	ng the benefits and					
	•	ects of the immunization;					
	· ·	is offered an influenza					
		ober 1 through March 31					
	•	the immunization is					
		ndicated or the resident has					
	•	nunized during this time					
	period;						
		or the resident's legal					
		s the opportunity to refuse					
	immunization; and						
		s medical record includes					
		at indicates, at a minimum,					
	the following:						
		dent or resident's legal					
		as provided education					
		nefits and potential side					
		ra immunization; and					
	` '	dent either received the					
		zation or did not receive the					
	contraindications	zation due to medical					
	Contraindications	or refusal.					
	The facility must o	develop policies and					
	procedures that e						
	•	the pneumococcal	1				
		ch resident, or the					
		epresentative receives					
		ing the benefits and					
		ects of the immunization;					
	•	is offered a pneumococcal					
	* *	less the immunization is					
		ndicated or the resident has					
	already been imm						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 29 of 76

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		155793	B. WING			01/16/	2013
NAME OF B	DOLUMEN OF GLIPPI IEE		STI	REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	C	11	1851 C	UMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC	FIS	SHER	S, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG			TA	λG	DEFICIENCY)		DATE
TAG	(iii) The resident of representative has immunization; and (iv) The resident's documentation that the following: (A) That the reserepresentative was regarding the bereffects of pneumon (B) That the resepneumococcal impreceive the pneumococcal impreceive the pneumon to medical contration of the facility failed consents for in pneumococcal facility failed to resident's medical contration register in the facility failed consents for in pneumococcal facility failed to resident's medical contration register in the facility failed to resident's medical to resident's medical to resident's of receptions.	or the resident's legal as the opportunity to refuse d s medical record includes at indicated, at a minimum, ident or resident's legal as provided education nefits and potential side occocal immunization; and ident either received the munization or did not mococcal immunization due indication or refusal. Live, based on an practitioner, a second pneumococcal y be given after 5 years pneumococcal less medically or the resident or the expresentative refuses the ation. Indications, and the odocument in the ical record that parding the risks and eaving the	F0334	A.G		0	
	residents revie pneumococcal	wed for the and influenza ogram. (Resident #72, 24)			Residents, #110 and #124 responsible parties were notified, and consent or declination was received after	er	
			l				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 30 of 76

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X:		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DDIG	00	COMPL	ETED
		155793		LDING		01/16/2013	
			B. WIN		ADDRESS CITY STATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
		IEDO II O			CUMBERLAND RD		
HAMILIC	ON TRACE OF FISI	HERS LLC	FISHERS, IN 46037		RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					education was provided		
	1. The record for Resident #72 was				regarding the influenza and		
	reviewed on 1/	14/13 at 2:10 p.m.			pneumococcal immunizatio	n	
					vaccinations.		
	Diagnoses incl	uded, but were not					
					Letter to all responsible		
		entia with behavioral			parties educating them on t	he	
		ypertension, depressive			risks and benefits of the		
		etes and generalized			Influenza and Pneumococc	al	
	anxiety disorde	er.			immunization vaccines was		
					sent in September 2012.		
	An Electronic N	Medication Record			Follow up phone calls		
	[EMAR] for Re	sident #72 indicated			occurred for any		
	the influenza v	irus vaccine was			resident/responsible party t	hat	
	administered o				refused the vaccinations in		
		11 10/0/12.			October 2012.		
	A progress not	o dated 10/0/12 at					
		e, dated 10/9/12 at					
	1:26 p.m., for F						
		sident received (sic) Flu			Letter has been scanned in to		
		cination today.			residents #72, #110, #127,		
	Tolerated well,	no adverse reactins			and #124 medical records.		
	(sic) noted. W	ill continue to monitor."					
	The record for	Resident #72 lacked			II The feeility will identify		
	documentation	of a consent for the			II. The facility will identify	,	
		nation, and the record			other residents that may		
		entation that education			potentially be affected by		
					the deficient practice.		
		isks and benefits of the					
		s provided prior to					
	administering t	he influenza vaccine.			Resident medical records		
					were audited for declination	ı in	
		for Resident #110 was			the previous calendar year		
	reviewed on 1/	14/13 at 2:16 p.m.			determine residents who ha		
	Diagnoses incl	uded, but were not			the potential to be affected.		
	_	gestive heart failure,			Residents not receiving the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00		COMPLETED	
		155793	A. BUI B. WIN			01/16/2	2013
		L	D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			CUMBERLAND RD		
HAMILTO	ON TRACE OF FIS	HERS LLC		FISHERS, IN 46037			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	dementia, oste				vaccinations responsible		
	hypertension,	diabetes and anemia.			parties were notified, and		
					consent or declination was		
	The record for	Resident #110 lacked			received after education wa	as	
	documentation	n of a declination for the			provided regarding the		
	pneumococca	l and influenza			influenza vaccination.	d in	
	vaccination, a	nd the record lacked			Education was documente		
	-	that education			the resident's medical reco	nu.	
		risks and benefits of the					
		l and influenza					
	l •	as provided annually.			Letter to all responsible		
	vaccination we	ao provided armadily.			parties educating them on	the	
	3 The record	for Resident #127 was			risks and benefits of the		
					Influenza and Pneumococo	cal	
	reviewed on 1	/14/13 at 2:22 p.m.			immunization vaccines was	s	
]				sent in September 2012, a	nd	
	_	luded, but were not			has been scanned in to		
		ebrovascular disease,			resident's medical records.	.	
	hypertension,						
		turbance, depressive					
	disorder and o	steoporosis.			III. The feetlife will need be		
					III. The facility will put int	io	
	An EMAR for I	Resident #127 indicated			place the following		
	the influenza v	rirus vaccine was			systematic changes to		
	administered of	on 10/27/12.			ensure that the deficient		
					practice does not recur.		
	A progress no	te, dated 10/27/12 at					
	3:38 p.m., for						
	' '	u [influenza] vaccine			Facility will provide annual		
		g deltoid. Tolerated			influenza and pneumococo	I	
	well."	., acitola. Toloratoa			immunization vaccine		
	VVCII.				education to each		
	The record for	Docidont #197 leaked			resident/responsible party		
		Resident #127 lacked			annually. A copy of the		
		n of a consent for the			education provided will be		
		ination, and the record			documented in the residen	ťs l	
	Llacked docume	entation that education			1		

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155793	B. WIN		-	01/16/	/2013
E 0E 1					ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	ę.		11851	CUMBERLAND RD		
HAMILTO	ON TRACE OF FISI	HERS LLC		FISHER	RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		risks and benefits of the			medical record.		
	vaccination was provided prior to administering the influenza vaccine.						
	administering t	ne miluenza vaccine.					
	1 The need of	for Dooldont #404			Resident/responsible party		
		for Resident #124 was			sign consent upon admissi		
	reviewed on 1/	14/13 at 2:40 p.m.			stating that they have been	1	
	Diameter in a	uded but were as			educated on the risks and	1	
	1	uded, but were not			benefits of the Influenza ar		
		orovascular disease,			Pneumococcal immunization		
	-	order, dementia with			vaccines and accept or der the vaccine. The form will	-	
	delusions, and	nypertension.			placed in the resident's	De	
		D : 1 / //4041 1 1			medical record upon receip	ot.	
		Resident #124 lacked			l moundair rooma alpoin room		
		of a declination for the					
	pneumococcal						
	-	nd the record lacked			RN/LPN will provide annua	i l	
		that education			flu/pneumonia vaccine		
		risks and benefits of the			education prior to giving immunizations. Residents		
	pneumococcal				refusing vaccines in the pa	et	
	vaccination wa	s provided annually.			will be given education and		
					given the opportunity to	-	
	_	view on 1/14/13 at			accept or refuse the		
		DoN indicated the			immunization on an annual	l	
		resident's responsible			basis. Education will be		
		consent or declination			documented in the residen	t's	
		ococcal and influenza			medical record.		
	l '	pon admission. The					
		the consent contained					
		at indicated the			IV The facility will monit	tor	
		r responsible party			the corrective action by		
		e to resign the form for			implementing the following	าต	
		of the resident's stay,			measures.	-3	
		y facility staff if they					
		nge the decision. The					
	DoN indicated	education regarding					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793		IULTIPLE CO LDING	00	(X3) DATE S COMPL 01/16/	ETED
		155795	B. WIN			01/10/	2013
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
HAMILTO	ON TRACE OF FISH	HERS LLC			CUMBERLAND RD RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	the risks and b	enefits of the			HIM Director or designee w	rill	
	pneumococcal				track consents monthly and		
	l •	as sent annually to			report findings to DON. An	y	
		informed; however,			consent not received will		
	the DoN could				receive a follow up call to		
		of the education on			re-educate and determine		
		nedical record for			vaccination status.		
		, #110, #127 or #124.					
	The facility poli	cy provided by the			Results of the reviews will be	oe .	
	DoN on 1/7/13	• •			presented at the monthly		
		ne resident or legal			Quality Assurance Commit	ee	
	· ·	will be provided			meetings and frequency an	d	
	· ·	d education regarding			duration of reviews will be		
		d potential side effects			adjusted as needed.		
		a vaccinations on an					
		Provision of such					
		be documented in the					
	resident's med	ical recordA consent					
	form will be sig	ned to designate			V. Plan of Correction		
		ent or refusal of the			completion date.		
	influenza vacci	nethey will not have					
		orm for succeeding					
	yearsbut mus	st notify the facility of			Plan of Completion date is		
	this decision ch	nange. Unless			February 15, 2013.		
	otherwise notif	ied, the facility will					
	administer the	vaccine on an annual					
	basis. If the re	sident and/or					
	responsible pa	rty refuses the					
	administration	of the vaccine, they will					
	continue to rec	eive the information					
	and education	regarding the benefits					
	and potential s	ide effects annually.					
	Continued refu	sal will be documented					
	in the medical	record"					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 34 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155793	B. WING		01/16/2013			
NAME OF P	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE				
			11851 CUMBERLAND RD FISHERS, IN 46037					
	ON TRACE OF FIS			RS, IN 46037				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5)			
PREFIX TAG	1	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE			
		,						
	3.1-13(a)							
	,							
					1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 35 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793		(X2) MULTIPLE A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/16/2013	
	ROVIDER OR SUPPLIER		STREE 1185	ET ADDRESS, CITY, STATE, ZIP CODE 1 CUMBERLAND RD IERS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F0356 SS=C	483.30(e) POSTED NURSE INFORMATION The facility must period information on a control of the current date of the total number worked by the following the following the following the following the following the following the facility must provided the facility pro	e. er and the actual hours lowing categories of censed nursing staff directly sident care per shift: nurses. actical nurses or licensed is (as defined under State rese aides. is. post the nurse staffing data an a daily basis at the in shift. Data must be cable format. place readily accessible to itors. upon oral or written irse staffing data available eview at a cost not to nunity standard. maintain the posted daily a for a minimum of 18 juired by State law,	IAG		DATE
	Based on obsethe facility faile display, in an a and frequented written data rel	ervation and interview d to prominently accessible l by most residents, ated to daily nursing deficiency had the	F0356	F356 I. The corrective actions to be accomplished those residents found to ha been affected by the deficie practice. The required nur staffing information was post during the survey beside the	ent ese ed

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet

Page 36 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIG	00	COMPL	ETED
		155793	A. BUII B. WIN			01/16/	2013
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8			CUMBERLAND RD		
⊔∧MII T∂	ON TRACE OF FISH	JEDS II C			RS, IN 46037		
	ON TRACE OF FISH	IENS LLC		FISHER			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	_	DATE
	potential to affe	ect 100 of 100			entrance in the main lobby of		
	residents resid	ing in the certified			community. Residents #134,		
	nursing facility	area.			and family member of residen #47 were notified of the location		
					of the nurse staffing information		
	Findings include:				II. The facility will identif		
					other residents that may	,	
	The initial obse	ervation tour was			potentially be affected by the	•	
		1/7/13, beginning at			deficient practice. Residen	nt's	
		•			residing in the facility had the		
	10:05 A.M., on the 300-400 Wing,					I.	
	600-700 Wing, 800 Wing, and				The facility will put into place	е	
	500/Alzheimer's secured locked unit.				the following systematic		
	Posted information related to daily				changes to ensure that the		
	nursing staffing was not located on				deficient practice does not		
	any of the units	S.			recur. All new admissions a their families will be educated	and	
					upon admission on how to loc	ate	
	On 1/7/13 at 1	1: 30 A.M. an			the staffing posting. In addition		
	observation wa	as done in the front			each unit has a posting detaili		
		ain facility entrance.			the location of the nurse staffing		
	_	n piece of paper, listing			information within the facility.		
		's nursing staffing, was		IV The facility will monitor the			
					corrective action by		
		all clear plastic holder,			implementing the following		
		ced on table in the			measures. The posting will		
	1	ne main entrance. The			reviewed monthly for 6 months ensure compliance. Locati		
		vas turned slightly, so			of nurse staffing information w		
	that it was facir	ng away from main			be reviewed in resident counc		
	entrance doorv	vay and traffic pattern.			monthly 3 months then quarte		
					thereafter for a total of 12	_	
	During the dail	y conference on			months. Results of this au		
	1/11/13 at 4:45				will be reviewed at the monthly		
		and Consultant Nurse			Quality Assurance Committee		
		ursing staffing data			meeting and frequency and duration of reviews will be		
		the plastic holder on			adjusted as needed. V.		
	•	•			Plan of Correction completion	n	
		front lobby, and was			date. Plan of Completion da		
	_	all residents. They			is February 15, 2013.	210	
	Lindicated the fa	acility did not post this	1		1		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 37 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155793	B. WIN		<u> </u>	01/16/	2013
	PROVIDER OR SUPPLIEF		•	11851 C	ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037	-	
				<u> </u>	,		(VE)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		each unit in order to					
	make the area	s more home-like.					
	In an interview on 1/14/13 at 11:19 A.M., Resident #134 indicated she						
	•	ny posted information					
		nursing staffing, but					
	,	like to know where it					
	was. She indic	cated she was able to					
	get around the facility using her wheelchair, but did not go to the front lobby.						
	In an interview on 1/14/13 at 11:27 A.M., Resident #37 indicated she had						
	not seen any p	osted notice related to taffing. She indicated					
	she was able t	o get around the facility elchair, but did not go					
	to the front lob						
		on 1/14/13 at 11:34					
	1	member for Resident she had had seen the					
	_	on front table in the t had only noticed it					
	one day when	she was leaving. The					
		ted he had not seen					
	was.	did not know where it					
	3.1-13(a)						
	,						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 38 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	COM	TE SURVEY IPLETED			
		155793	B. WING			16/2013		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 39 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	A. BUILDING 00		COMPLETED	
		155793	A. BUILDING B. WING			01/16/	2013
			B. WIN	_	ADDRESS CITY STATE OF CORE		
NAME OF P	ROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
	TD 4 OF OF FIGU	IEDO I I O			CUMBERLAND RD		
HAMILIC	N TRACE OF FISH	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.2	DATE
F0371	483.35(i)						
SS=F	FOOD PROCURE	Ε,					
	STORE/PREPAR	E/SERVE - SANITARY					
	The facility must -						
	· ·	from sources approved or					
		actory by Federal, State or					
	local authorities;						
	under sanitary co	e, distribute and serve food				ļ	
	•		F03	71	5074 J. The second still		02/15/2013
		rvation, record review	1 503	/ 1	F371 I. The corrective	ior	02/13/2013
		the facility failed to			actions to be accomplished f those residents found to hav		
		as served in a sanitary			been affected by the deficien		
	manner for resi	idents. This practice			practice. No residents were		
	had the potential to affect 96 of 100 residents who eat food served from				identified as having been	'	
					affected. Dining Services		
	the kitchen.				employee was re-educated on		
					proper food handling technique		
	Findings includ	۵.			II. The facility will identify	y	
	i indings includ	C .			other residents that may		
	la an abaamat	4/7/40 -+ 40-00			potentially be affected by the	,	
		on on 1/7/13 at 12:20			deficient practice. Residen		
	•	id # 1 after touching			who receive pureed meals in t	he	
	scoops, steamt	table separators, hot			Skilled Dining room could be		
	pads, and pape	er towel holder placed			affected. III. The facility v	vill	
	her bare fingers	s in pureed bread and			put into place the following		
		outting the steampan			systematic changes to ensur		
		ack into the wells. She			that the deficient practice do	es	
		sidents in the skilled			not recur. Current Dining		
	_				Service employees were re-educated on proper food		
	nursing aining a	area at the time.			handling techniques. IV	The	
					facility will monitor the	1110	
		with the Administrator,			corrective action by		
	on 1/16/13 at 9	:15 A.M., she indicated			implementing the following		
	this should not	happen when			measures. Dining Services	ļ	
	residents are b	eing served their food.			employees in the skilled dining		
		<u> </u>			room will be monitored 3 times		
	A nolicy regard	ing handling of food			week for 4 weeks, weekly time	s 4	
		esidents in dining areas			weeks, monthly times 1 month	i	
	wille serving it	colucino in unilly aleas			then quarterly thereafter for a		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 40 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	00	COMP	LETED
	155793	B. WING		01/16	8/2013
OVIDER OR SUPPLIER		11851	CUMBERLAND RD	ODE	
SUMMARY ST (EACH DEFICIENC REGULATORY OR was requested The policy that glove use whicl	HERS LLC FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) On 1/8/13 at 4:15 P.M. was provided was on h did not apply due to	B. WING STREET . 11851	CUMBERLAND RD RS, IN 46037 PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AIDEFICIENCY) total of 12 months for for service compliance. this audit will be review monthly Quality Assura Committee meeting and frequency and duration will be adjusted as need V. Plan of Correction completion date.	DDE RECTION OULD BE PPROPRIATE DOD Results of ed at the ence d of reviews ded. an of	(X5) COMPLETION DATE
	OVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENT REGULATORY OR Was requested The policy that glove use whice Dietary Aid #1 the time.	DENTIFICATION NUMBER: 155793 OVIDER OR SUPPLIER N TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) was requested on 1/8/13 at 4:15 P.M. The policy that was provided was on glove use which did not apply due to Dietary Aid #1 not having gloves on at the time.	TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was requested on 1/8/13 at 4:15 P.M. The policy that was provided was on glove use which did not apply due to Dietary Aid #1 not having gloves on at the time.	TOVIDER OR SUPPLIER OVIDER OR SUPPLIER N TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The policy that was provided was on glove use which did not apply due to Dietary Aid #1 not having gloves on at the time. STREET ADDRESS, CITY, STATE, ZIP CO 11851 CUMBERLAND RD FISHERS, IN 46037 FISHERS, IN 46037 ID PROVIDERS PLAN OF CORE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE A DEFICIENCY) TAG Total of 12 months for for service compliance. this audit will be review monthly Quality Assura Committee meeting and frequency and duration will be adjusted as neer V. Plan of Correction completion date. Plan Completion date is Feb.	TOVIDER OR SUPPLIER IN TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was requested on 1/8/13 at 4:15 P.M. The policy that was provided was on glove use which did not apply due to Dietary Aid #1 not having gloves on at the time. 3.1-21(i)(3) STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) total of 12 months for food service compliance. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is February 15,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 70YU11

Facility ID: 012644

If continuation sheet Page 41 of 76

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793 NAME OF PROVIDER OR SUPPLIER IDENTIFICATION NUMBER: 155793 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD	
155793 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	
HAMILTON TRACE OF FISHERS LLC FISHERS, IN 46037	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETI	ON
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE	
R0000	
The following Residential findings were cited in accordance with 410 IAC 16.2-5. R0000 February 8, 2013 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Merdian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on January 16, 2013. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on February 15, 2013. We are requesting a desk review for this plan of correction. If If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of ishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Annual	

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 42 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	(X3) DATE SURVEY COMPLETED			
		155793	A. BUILDING B. WING		01/16	/2013	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-		
HAMILTO	ON TRACE OF FISH	HERS LLC	11851 CUMBERLAND RD FISHERS, IN 46037				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Recertification and State Licensure Survey on Janu 2013. Please accept this p correction as Hamilton Tra Fisher's credible allegation compliance by February 1. This statement of deficient and plan of correction will reviewed at the April Quali Assurance/Assessment Committee meeting.	ary 16, plan of nce of n of 5, 2013. cies be	DATE	

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 43 of 76

IDENTIFICATION NUMBER 156793 SURLICE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC (V4) ID SUMMARY STATEMENT OF DEFICIENCIES FISHERS, IN 46037 ID SUMMARY STATEMENT OF DEFICIENCIES LACE ID BETTERN WAST BE PRECIDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 10 A 10 A 10 A 2-5 1 2 (a) Residents Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents "rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents" rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents resident understands. Based on observation and interview, the facility and the potential to affect 32 of 32 residents residents found to have been affected by the deficient practice. Resident's resident that may potentially be affected by the deficient practice. Resident's r	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00 COMPLETED			ETED	
NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC (2A) ID SIMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) ROOZE At 10 IAC 18.2-5-1.2(a) Residents Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies reparting residents' rights and responsibilities in accordance with this article and shall be responsible. Through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the residents' rights prior to admission and thereafter if the residents' rights are updated or changed. There shall be documentation that each resident sin receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents rights and responsibilities and responsibilities. A copy of the residents in receipt of the described residents' rights and responsibilities. A copy of the residents rights and responsibilities and responsibilities and responsibilities. A copy of the residents rights and responsibilities and responsibilities and responsibilities and responsibil			155793				01/16/	2013
HAMILTON TRACE OF FISHERS LLC VALUE PREETX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION ATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Residents Rights - Noncompliance (a) Residents Rights - Noncompliance (a) Residents and the indight to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents' rights and responsibilities. A copy of the resident's rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on observation and interview, the facility failed to prominently display, in an area readily accessible and frequented by most residents written information related to Resident Rights. This deficiency had the potential to affect 32 of 32 residents residing in the licensed Residential/Assisted Living area of the facility. Findings include: During the environmental tour on				b. WIN		ADDRESS CITY STATE ZID CODE		
HAMILTON TRACE OF FISHERS LLC (XN) ID SUMMARY STATEMENT OF DEFICIENCIES TAG REGILATIONY OR INC IDENTIFYING INFORMATION) REGILATIONY OR INC IDENTIFYING INFORMATION) Residents Rights - Noncompliance (a) Residents have the right to have their right recognized by the Ilcenses. The licensee shall establish written policies regarding residents rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents rights and responsibilities. A copy of the resident is in receipt of the described residents rights and responsibilities. A copy of the resident is in receipt of the described residents rights and responsibilities. A copy of the resident is in receipt of the described residents rights and responsibilities. A copy of the residents rights and responsibilities. A copy of the resident is in receipt of the described residents rights and responsibilities. A copy of the resident is in receipt of the described residents rights and responsibilities. A copy of the resident rights and responsibilities. A copy of the resident rights and responsibilities. A copy of the resident rights and resident rights and resident rights. A copy of the resident right resident right resident rights and resident rights and resident rights. R0026 I. The corrective across scale right right right right righ	NAME OF P	ROVIDER OR SUPPLIER						
NAID	HAMILTO	N TRACE OF FISH	HERS LLC					
PREEX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) ROO26 410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents' Rights - Noncompliance (b) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the residents' rights prior to admission and thereafter if the residents' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents' rights and responsibilities. A copy of the residents' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents' rights and responsibilities. A copy of the residents' rights and responsibilities. A c								(Y5)
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defining and distinct markles described						·	ic	
1/16/13 at 8:50 A.M., with LPN #6 in		During the envi	ironmental tour on			_		
		1/16/13 at 8:50	A.M., with LPN #6 in			deficient practice does not		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 44 of 76

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			Y		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING 00 COMPLETED			
		155793	B. WING			01/16/2013	
NAME OF P	PROVIDER OR SUPPLIER		S	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDEK OK SUPPLIER	•] -	11851 C	CUMBERLAND RD		
	ON TRACE OF FISH				S, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	PLETION
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG			ATE
		copy of the Resident			recur. A copy of the required information for Resident Right		
	_	tion was not found to			has been posted. IV The	^	
	be posted in th				facility will monitor the		
	Residential/Ass	sisted Living area of			corrective action by		
	the facility.				implementing the following		
					measures. The posting will b	e	
	In an interview	at that time, LPN #6			reviewed monthly for 6 months		
		was a posted with			ensure compliance. Location	of	
		s, and pointed to a			the Resident Rights will be		
	framed sign on the wall in the center lounge area by the Nurse's Station.				reviewed in resident council monthly for 3 months then		
					quarterly thereafter for a total		
					of 12 months. Results of this	;	
	The sign was t	itled "Resident Rights			audit will be reviewed at the		
	for Housing wit				monthly Quality Assurance		
	_	s" and addressed			Committee meeting and		
					frequency and duration of revi		
		rather than Resident			will be adjusted as needed. \		
		ired and listed in the			Plan of Correction completion date. Plan of Completion dat		
	State Licensur	e rules.			February 15, 2013.	5 15	
	The nurse indic	cated she thought that					
	was the correc	t information, and it					
		gn currently posted.					
		- • •					
	In an interview	on 1/16/13 at 10:00					
		#205 indicated she					
	•	ny signs related to					
	Resident Right	, ,					
		~ ·					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 45 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/16/2013	
	ROVIDER OR SUPPLIER		STREE 11851	T ADDRESS, CITY, STATE, ZIP CODE 1 CUMBERLAND RD ERS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0033	(h) The facility muthe following: (1) A statement the complaint with the resident abuse, in resident property, facility. (2) The most received telephone number (A) The department (B) The office of the social services. (C) The ombuds in division of disability services. (D) The area age (E) The local mere (F) Adult protection The addresses and this subdivision is accessible to residual appropriate. Based on obsett the facility failed display, in an anamed frequented written information names/address all pertinent States This deficiency affect 32 of 32 the licensed Relation and the states of the facility failed display in an anamed frequented written information names and frequented written information names and frequented written information names and frequented from the facility failed display in an anamed frequented written information names and frequented from the facility failed display in an anamed frequented from the facility failed from the facility f	- Noncompliance ust furnish on admission nat the resident may file a e director concerning eglect, misappropriation of and other practices of the ently known addresses and rs of the following: ent. he secretary of family and han designated by the ty, aging, and rehabilitation here, on aging. Hal health center. He services. He delephone numbers in hall be posted in an area dents and updated as rvation and interview, d to prominently rea readily accessible by most residents, tion related to the less/phone numbers of late advocacy groups. had the potential to residents residing in lesidential/Assisted he facility.	R0033	R0033 I. The corrective actions to be accomplished those residents found to have been affected by the deficient practice. Resident #205 (should be #505) was notified the location of the State advoct groups posting. II. The facility will identify other residents that may potentiall be affected by the deficient practice. Resident's residing the facility had the potential to affected. III. The facility will put into place the following systematic changes to ensure that the deficient practice do	of cacy ly ng in be ill

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 46 of 76

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED - 01/16/2013			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION PROPRIATE DATE			
	attendance, a cadvocacy group found to be positive. Residential/Assiste facility. In an interview indicated she will numbers were linear interview A.M., Residential not seen a secondary and not seen a secondary group.	O A.M., with LPN #6 in copy of the State ps information was not sted in the licensed sisted Living area of at that time, LPN #6 was not aware the required to be posted. on 1/16/13 at 10:00 at #205 indicated she any signs with the ncy information.		of the state advocacy grown be reviewed in resident monthly for 3 months th quarterly thereafter for a	all vocacy d. IV r the wing ng will be months to Location roups will council en a total lts of this t the nce d of reviews ded. V. npletion			

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 47 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155793	A. BUII			01/16/	2013
		100700	B. WIN			0 17 107	2010
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
			11851 CUMBERLAND RD				
HAMILTO	N TRACE OF FISH	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	I C	DATE
R0090	410 IAC 16.2-5-1	.3(a)(1-6)					
	Administration an	· · · · · · · · · · · · · · · · · · ·					
	Deficiency	a managaman					
	•	ator is responsible for the					
		ent of the facility. The					
		the administrator shall					
	•	ot limited to, the following:					
		division within twenty-four					
	` '	oming aware of an unusual					
		irectly threatens the					
	welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the						
	twenty-four (24) hour time period. Unusual						
	• • •	ide, but are not limited to:					
	(A) epidemic outb						
	(B)poisonings;	orears,					
	(C) fires; or						
	(D) major accider	ate					
	• •	not be reached, a call shall					
	number published	mergency telephone					
		nging for or assisting with nedical, dental, podiatry, or					
		ther health care services as resident or resident's legal					
		resident of resident's legal					
	representative.	eter approval prior to the					
		ctor approval prior to the ndividual under eighteen					
		to an adult facility.					
	· , ,	-					
	` '	acility maintains, on the					
	•	urate record of actual time					
	worked that indica						
	(A) employee's fu						
		urs worked during the past					
	twelve (12) month						
		sults of the most recent					
		the facility conducted by					
		any plan of correction in					
	enect with respec	t to the facility, and any					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 48 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN	G		01/16/	2013
	PROVIDER OR SUPPLIER			11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	available for examplace readily according posted of to (6) Maintaining reby the division in two (2) years and available for inspetting public upon rebased on obsetting the public upon rebased on obsetting the facility failed display and posavailability in a most residents most recent surederal or Statistic plan of correcting the facility. Findings include the facility. There were noticed the facility at the entrance of the e	eports of surveys conducted each facility for a period of making the reports ection to any member of equest ervation and interview, d to prominently st a notice of their narea frequented by, the results of the rvey conducted by es surveyors, and any on. This deficiency all to affect 32 of 32 ing in the licensed sisted Living area of le: ironmental tour on A.M., with LPN #6 in binder containing the was located on a table	ROO	090	R0090 I. The corrective actions to be accomplished if those residents found to hav been affected by the deficien practice. The survey results binder was displayed in the frol lobby beside the main entrance the community. Resident #200 (should be #505) was notified the location of the survey results. In the facility will identify other residents that may potentially be affected by the deficient practice. Residen residing in the facility had the potential to be affected. Ill The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. All new admissions at their families will be educated upon admission on how to locate the survey results. IV The facility will monitor the corrective action by implementing the following measures. The posting will reviewed monthly for 6 months ensure compliance. Location of survey results binder will be reviewed in resident council.	e t s ont e in 5 of lts. t's e nd ate e be s to on	02/15/2013

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 49 of 76

	OF CORRECTION OF CORRECTION 155793	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/16/2013
	PROVIDER OR SUPPLIER ON TRACE OF FISHERS LLC	11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	on the first or second floor of the Residential area. In an interview at that time, LPN #6 indicated there were no notices posted, and a resident "could ask for the information on where to find the book." She did not know how they would locate the survey book unless they asked staff. In an interview on 1/16/13 at 10:00 A.M., Resident #205 indicated she did not know where the survey book was, and had not seen any signs on its location.		monthly for 3 months then quarterly thereafter for a total 12 months. Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of revi will be adjusted as needed. V. Plan of Correction completion date. Plan of Completion date is February 1 2013.	ews

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 50 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
			D. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.			CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC			RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0148	(e) The facility sh grounds, and equation, in good that may adverse welfare of the rest follows: (1) Each facility simplement a writt maintenance to eupkeep of the facility sources, fire alarm shall be maintained functioning and concept with state (4) At least yearly systems shall be Based on obsetthe facility failed commonly used that were free for This deficiency affect 32 of 32 the licensed Relations included The environments.	afety Standards - Deficiency all maintain buildings, sipment in a clean direpair, and free of hazards by affect the health and idents or the public as thall establish and en program for insure the continued sility. System, including so, switches, alternate power in and detection systems, ed to guarantee safe compliance with state shall function properly and explumbing codes. An heating and ventilating inspected. Envation and interview, did to ensure 4 did dryers had lint traps from a build-up of lint. And the potential to residents residing in esidential/Assisted the facility. Ite: Sental tour was 1/16/13 at 8:50 A.M.,	R01	48	R0148 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. The lint traps in the dryers of the common laundry rooms on the first and second floor have been cleaned. II. The facility will identify other residents that may potentially be affected by the deficient practice. Residents residing the facility could have been affected. III The facility will put into place the following systematic changes to ensurthat the deficient practice do	e t e y g in	02/15/2013
		aundry rooms on the d floors each had two			not recur. AL staff were re-educated on the cleaning of	f	

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 51 of 76

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/16/2013				
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE				
	dryers had a he from usage. In an interview indicated the Hopartment we cleaning the linat least daily.	ere responsible for an art traps, and they did so she did not know if and cleaned the lint		the lint traps in the dryers common laundry rooms. Common laundry room li will be checked daily to edryers are free of lint. The facility will monitor corrective action by implementing the follow measures. Environmed Services Director or desi complete visual observator traps 5 times a week for weekly for 2 months their quarterly thereafter for a 12 months. Results of monthly observation will reviewed at the monthly Assurance Committee mand frequency and durator reviews will be adjusted an needed. V. Plan of Correction completion date February 15, 2013.	nt traps ensure IV the ving ental gnee will tion of lint 4 weeks, n total of of the be Quality eeting ion of as date.				

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 52 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			CUMBERLAND RD		
HAMII TO	N TRACE OF FISH	JEDS II C			RS, IN 46037		
TIAMILIC	IN TRACE OF FISI	IERS EEC		FISHER	N3, IN 40037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0214	410 IAC 16.2-5-2	(a)					
	Evaluation - Defice	<u> </u>					
	` '	of the individual needs of					
		all be initiated prior to					
		nall be updated at least					
		d upon a known substantial					
	-	ident 's condition, or more ent 's or facility 's request.					
		shall evaluate the nursing					
	needs of the resid						
	Based on obse	ervation, record review	R02	14	R0214 I. The corrective		02/15/2013
		the facility failed to	1102		actions to be accomplished	for	02/10/2015
		esident after a fall for			those residents found to hav		
					been affected by the deficien	_	
	•	actors and failed to			practice. Resident #509 ha		
	re-evaluate a re	esident with behaviors			had a fall risk assessment		
	when a change	e in condition occurred			completed. Resident has had	no	
	for 2 of 8 reside	ents reviewed out of a			further falls from bed. Resid	lent	
	census of 36 re	esidents. (Resident			#538 has been discharged.		
	#509, #538).	`			II. The facility will identify		
					other residents that may		
	Findings includ	lo:			potentially be affected by the)	
	Findings includ	ie.			deficient practice. Residen		
					with falls or behavior changes		
		for Resident #509 was			have the potential to be affect		
	reviewed on 1/	16/13 at 10:00 a.m.			III The facility will put int		
					place the following systemat	IC	
	Diagnoses incl	uded, but were not			changes to ensure that the deficient practice does not		
	limited to, dysp				recur. Licensed nursing sta	ff	
	weakness, oste	•			were re-educated on the	11	
	hypertension.					λL	
	пурспензіон.				IDT have been educated on the		
	A	- data d 44/00/40 -t			requirement to complete post		
	•	e, dated 11/28/12 at			observations and update resid		
	10:05 p.m., for				service plans for any resident		
	indicated, "Res	s [resident] was incont			who have a fall or new/worser	-	
	[incontinent] of	urine before dinner			behaviors. IV The facility	•	
	and before goin	ng to bedCNA			will monitor the corrective		
	_	ing Assistant] assisted			action by implementing the		
	-	ht] ADL's [activities of			following measures. DON	or	

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 53 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	C	00	COMPL	ETED
		155793	A. BUILDING B. WING	u		01/16/	2013
			_	DEET V	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	ER			CUMBERLAND RD		
HAMII TO	ON TRACE OF FIS	CHEDSIIC			S, IN 46037		
		STIENS LEG		OI ILIN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	·	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	daily living] r/t	[related to] gait slightly			designee will audit posclinical		
	unsteady."				records of residents who fall o		
					have new/worsening behaviors		
	A progress no	ote, dated 12/07/12 at			weekly for 4 weeks, monthly for months, then quarterly thereaf		
	. •	Resident #509			for a total of 12 months.	.01	
	· ·	s called for help via call			Results of this audit will be		
		nd res on floor between			reviewed at the monthly Qualit	ty	
	•	stand with blood to face.			Assurance Committee meeting	•	
	_				and frequency and duration of		
		ollen and right eye orbit			reviews will be adjusted as		
		ng of blue and red to			needed. V. Plan of		
		checks doneto ER			Correction completion date.		
	[emergency ro	oom]"			Plan of Completion date is February 15, 2013.		
					1 Cordary 13, 2013.		
	A progress no	te dated 12/07/12 at					
	10:52 a.m. for	Resident #509					
	indicated, "Re	sident returned form					
		ident alert and oriented.					
	•	dx [diagnosis] of closed					
	fracture of nas						
	l lacture of flas	sai bones					
	Ah	data d 40/07/40 at					
		note, dated 12/07/12 at					
		icated Resident #509					
	was evaluated	d related to the fall.					
	A progress no	te, dated 12/07/12 at					
	11:28 p.m., fo	r Resident #509					
	-	s called for helpto get					
		bed. Gait is weak and					
		ady staff needed to gave					
		e assist with ambulance					
	l ` '						
	` '	elp get into bed and					
		over to middle of					
		e rail provided by family					
	put in place						

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 54 of 76

AND PLAN OF CORRECTION IDSTRIBLE AT DOMESTIC OF SUPPLIER HAMILTON TRACE OF FISHERS LLC (A) ID SUMMARY STATEMENT OF DEFICIENCES PRETEX GLACU BEFCENCY MUST BE PRECEDED BY PLI. TAG A progress note, dated 12/10/12 at 7.50 p.m., for Resident #509 indicated, "mbulatory with RW [rolling walker]. Gait slow, but steady." A progress note, dated 12/13/12 at 10.34 p.m., for Resident #509 indicated, "mahbulatory with RW [rolling walker]. Gait slow, but steady." A progress note, dated 12/16/12 at 10.09 p.m., for Resident #509 indicated, "mahbulatory with RW [rolling walker]. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10.09 p.m., for Resident #509 indicated, "mahbulatory with RW [rolling walker]. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10.09 p.m., for Resident #509 indicated, "ses requires some asstance (sic) with PM ADL's this evening and help to put up side rail." A fall event, dated 12/07/12 at 6:09 a.m., indicated that possible contributing factors were Arthritis and Osteoporosis. The intervention indicated, "bed rail under mattress" The most recent service plan indicated, "bed rail bulate ad lib [as desires] with/without device without fall or injury for six months. Approach Start Date: 10/30/20112 Monitor	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC (X4) ID PRIETX TAG A progress note, dated 12/10/12 at 10/34 p.m., for Resident #509 Indicated, "Assisted res to bathroomnoting gait is slighly (sic) unsteadyencouraged res to call for help when she feel weaker. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10/34 p.m., for Resident #509 Indicated, "Assisted res to bathroomnoting gait is slighly (sic) unsteadyencouraged res to call for help when she feel weaker. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10:09 p.m., for Resident #509 Indicated, "Res requires some asstance (sic) with PM ADL's this evening and help to put up side rail." A fall event, dated 12/07/12 at 6:09 a.m., indicated that possible contributing factors were Arthritis and Osteoporosis. The intervention indicated, "bed rail under mattress" The most recent service plan indicated, "MobilityLong Term Goal Target Date: 04/30/2013 Resident will ambulate ad lib [as desires] with/without device without fail or injury for six months. Approach	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	I DING	00	COMPL	ETED
NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC (X4) ID SENEMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL TAG A progress note, dated 12/10/12 at 7:50 p.m., for Resident #509 indicated, "Ambulatory with RW [rolling walker]. Gait slow, but steady." A progress note, dated 12/13/12 at 10:34 p.m., for Resident #509 indicated, "assisted res to bathroomnoting gait is slighly (sic) unsteadyencouraged res to call for help when she feel weaker. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10:09 p.m., for Resident #509 indicated, "Res requires some asstance (sic) with PM ADL's this evening and help to put up side rail." A fall event, dated 12/07/12 at 6:09 a.m., indicated that possible contributing factors were Arthritis and Osteoporosis. The intervention indicated, "bed rail under mattress" The most recent service plan indicated, "bed rail umbulate ad lib [as desires] with/without device without fall or injury for six months. Approach			155793				01/16/	2013
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HAMILTON TRACE OF FISHERS LLC IXM D SUMMARY STATEMENT OF DETICIENCIES TAG REGULATORY OR LSC IDENTIFYNO INFORMATION) A progress note, dated 12/10/12 at 7:50 p.m., for Resident #509 indicated, " Assisted res to bathroomnoting gait is slighly (sic) unsteadyencouraged res to call for help when she feel weaker. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10:34 p.m., for Resident #509 indicated, " Assisted res to bathroomnoting gait is slighly (sic) unsteadyencouraged res to call for help when she feel weaker. Side rail on bedcall pendent on person" A progress note, dated 12/16/12 at 10:09 p.m., for Resident #509 indicated, " Res requires some asstance (sic) with PM ADL's this evening and help to put up side rail." A fall event, dated 12/07/12 at 6:09 a.m., indicated that possible contributing factors were Arthritis and Osteoporosis. The intervention indicated, " bed rail under mattress" The most recent service plan indicated, " Mobility Long Term Goal Target Date: 04/30/2013 Resident will ambulate ad lib [as desires] with/without device without fall or injury for six months. Approach	NAME OF P	PROVIDER OR SUPPLIEF	₹					
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Goal Target Date: 04/30/2013 Resident will ambulate ad lib [as desires] with/without device without fall or injury for six months. Approach			•					
Resident will ambulate ad lib [as desires] with/without device without fall or injury for six months. Approach								
desires] with/without device without fall or injury for six months. Approach		_						
fall or injury for six months. Approach			-					
		-						
Start Date: 10/30/2012 Monitor		fall or injury for	six months. Approach					
Gtatt Date. 10/00/2012 Monitor		Start Date: 10	/30/2012 Monitor					
resident activities toleranceAssist if		resident activit	ies toleranceAssist if					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 55 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN	G		01/16/	2013
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
	N TD 4 OF OF FIG	UEDO LLO			CUMBERLAND RD		
HAMILIC	ON TRACE OF FISI	HERS LLC		FISHER	RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	neededEvalu						
		tesident calls for					
		nm (sic) to get out of					
	•	om and to return to					
	bed"						
	On 1/10/10 -1	10.10 a.m. Desident					
		10:40 a.m., Resident					
		s observed to be a twin					
		a box springs and a					
	•	ess. A 1/2 side rail was					
		tween the box springs					
		and was not in the up the observation. The					
	·	was against the wall.					
	resident's bed	was against the wall.					
	During an inter	view on 1/16/13 at					
	_	esident #509 indicated					
	· ·	bed. She indicated she					
		to get up. She					
		uses the side rail at					
		icated she was					
	_	all staff before trying to					
	get out of bed	, ,					
	30. 00. 01 000	55i 5iiii.					
	During an inter	view on 1/16/13 at					
	_	rmation was requested					
	•	elated to Resident					
		uding an updated					
		arding risk factors and					
	_	or prevention related to					
	the resident's f	•					
	During an inter	view on 1/16/13 at					
	_	#6 indicated Resident					
	•	e fell out of was a twin					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 56 of 76

NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 (X5)	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER HAMILTON TRACE OF FISHERS LLC STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	AND PLAN	OF CORRECTION				00		
HAMILTON TRACE OF FISHERS LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 11851 CUMBERLAND RD FISHERS, IN 46037 (X5)			100700	B. WIN		DDDESS CITY STATE 7IB CODE	0 17 107	2010
HAMILTON TRACE OF FISHERS LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF P	PROVIDER OR SUPPLIEF	8					
PROVIDER'S PLAN OF CORRECTION	HAMILTO	ON TRACE OF FISI	HERS LLC					
								` ′
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
bed at the same height as the	1710		<u> </u>		1710			DATE
resident's current bed. LPN #6			_					
indicated the family replaced the bed	ļ							
after the resident's fall because it was		after the reside	ent's fall because it was					
an old bed with a wooden frame.								
LPN #6 indicated the resident had	ļ							
been instructed to call for help before			d to call for help before					
getting up.		getting up.						
During an observation with LPN #6		During an obse	ervation with LPN #6					
present on 1/16/13 at 3:45 p.m.,		_						
Resident #509's bed was measured	ļ	l •	•					
at 2 feet and 6 inches from the floor.		at 2 feet and 6	inches from the floor.					
			D : 1 / #500 1					
The record for Resident #509 lacked								
documentation of a thorough and updated evaluation for risk factors	ļ		_					
and interventions for prevention after								
a fall with injury.			•					
	ļ		,					
As of exit on 1/16/13 at 4:30 p.m., no		As of exit on 1	/16/13 at 4:30 p.m., no					
further documentation was provided.		further docume	entation was provided.					
2. The record for Decident #529 was		2 The record	for Docidont #520 was					
2. The record for Resident #538 was reviewed on 1/16/13 at 11:30 a.m.								
10 violed on 17 to 10 at 11.00 a.m.		TOVICATOR 1/	10/10 at 11.00 a.m.					
Diagnoses included, but were not		Diagnoses incl	uded, but were not					
limited to, athlerosclerosis,	ļ	_						
hypertension and dementia.		hypertension a	nd dementia.					
A properties in the stimular of		A magazini	a franctional					
A preadmission functional assessment dated 5/9/12 for Resident								
#538 indicated the resident was								
independent with no assistance or								
cues for hygiene and grooming, was		•						

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 57 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN	IG		01/16/	2013
NAME OF F	ROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					CUMBERLAND RD		
HAMILTO	ON TRACE OF FISI	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	dressing and dresses					
		pendent in mobility,					
	•	bathing and required					
		showers, assessed as					
		ognition requiring cues					
		, assessed as minimal					
		pehaviors, independent					
		cial interactions,					
	independent w	•					
	occasional inco	ontinence.					
	. •	te, dated 5/26/12 at					
	1:56 p.m., for F						
		sident checked into					
	apartment"						
		1.1.10/04/40					
		te, dated 6/01/12 at					
	2:39 p.m., for F						
	· ·	sident seeks assistance					
	_	taff multiple times per					
		n roomResident is					
		me how to complete					
		resident unable to					
	perform per se	NT."					
	A progress set	to dated 6/07/12 at					
		te, dated 6/07/12 at					
	5:45 p.m., for F						
		s was sitting in dinning					
	` '	en staff noted bloody					
	_	ceRes had several					
		ving self to ear and					
	cheeks on righ						
		t staff assist him or					
	family to get el	ectric razor"					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 58 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			CUMBERLAND RD		
HAMILTO	ON TRACE OF FISI	HERS LLC			RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A progress not	te, dated 6/10/12 at					
	1:28 p.m., for F						
		esident is still wearing					
		ingthat he had on					
		_					
	1 *	ubble noted on face					
	''	resident has not					
	shaved for sev	eral days."					
	. •	te, dated 6/11/12 at					
	11:25 a.m., for	Resident #538					
	indicated, "F	ellow residents have					
	voiced concerr	ns regarding resident					
	touching their	plates with his eating					
		been seen picking up					
	food from a res	. • .					
		ir mealStaff will begin					
	_	lent to and from					
	meals"						
	A progress not	te, dated 6/11/12 at					
		Resident #538 indicted,					
		quested scissors to cut					
		incont [incontinent] of					
		e of thisfowl (sic)					
		` '					
		o assist with peri care					
		es did not know what					
	to do"						
	A progress not	te, dated 6/16/12 at					
	. •						
	8:53 p.m., for F						
		ent needed reminders					
	to flush toilet.						
	Δ progress not	te, dated 6/27/12 at					
	. •						
	3:02 p.m., for F	769106111 #330					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 59 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		,	(X2) MULTIPL			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		COMPLI	
		155793	B. WING			01/16/	2013
NAME OF F	PROVIDER OR SUPPLIEF	R			SS, CITY, STATE, ZIP CODE		
HAMILTO	ON TRACE OF FISI	HERS LLC		HERS, IN	SERLAND RD 46037		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
	`			CRO	SS-REFERENCED TO THE APPROPRIA	TE	
(X4) IID PREFIX TAG	indicated resid that he picked nurse he had of with Lysol. The dark notified and the from the reside A progress not 7:32 a.m., for Findicated, "resconfusionsto with several bracked and the several bracked and several bracked an	ent had scabbed areas and he informed the disinfected the area e nurse smelled the ughter and doctor were e Lysol was removed ent's room. The dated 7/04/12 at Resident #538 has increase ol and urine in trashiefs in trash" The dated 7/31/12 at dicated Resident #538 another resident, not kissed you yet" The dated 8/04/12 at cated Resident #538 "Can I have a The dated Resident #538's ped up with paper aid wrappers and other resident #538 skin and staff	TAG	CRO	ACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION DATE
		bserve the resident redirected when he					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 60 of 76

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155703	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY MPLETED 16/2013
		155793	B. WING			16/2013
	PROVIDER OR SUPPLIER		11851 (ADDRESS, CITY, STATE, ZIF CUMBERLAND RD RS, IN 46037	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	•	ng his skin. Staff the resident 3 times to brief.				
	6:19 p.m., indiconfused and	re, dated 10/12/12 at cated the resident was became inpatient and arsh and irritated when				
	2:58 p.m., indic unable to do si month and a h increasingly ur change pull up	te, dated 10/16/12 at cated, "Res has been imple ADL's for last alf. Res has been haware of the need to and often walks th soiled pull up"				
	7:02 p.m., indi	re, dated 11/11/12 at cted Resident #538 directions from the				
	8/1/12 at 10:37 "Hygiene & Completes task and little assist completes task and assistance appropriately; cuesEpisode physical; verba	requires verbal es involving l/disruptive cult to reason with;				

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 61 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155793	B. WIN	G		01/16/	2013
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TOTAL OF T	NO VIDEN ON SOITEEL				CUMBERLAND RD		
HAMILTO	ON TRACE OF FISH	HERS LLC		FISHER	RS, IN 46037		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	monthOccas	ionally incontinent"					
	p.m., indicated GroomingRe assistance to comonitors self-eassistance with cues and assisted reach areasFappropriately; cues and reminders and reminders and remainders and remainder	ated 11/16/12 at 2:18 , "Hygiene & quires cues, general complete tasks, staff offortNeeds some in dressingRequires sit with washing hard to Responds requires frequent verbal indersConsistent, conable and controlled inence/Toileting:Need					
	3:30 p.m., LPN started talking prior to the resident states issues, but the phone calls. L Resident #538 risk and was earth #6 indicated the	rview, on 1/16/12 at I #6 indicated she to the family 60 days ident's discharge when arted having toilet family did not return PN #6 indicated was never a wander asily re-directed. LPN e resident was ntil the very end."					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 62 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE (COMPL - 01/16/	ETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO CUMBERLAND RD	DE	
HAMILTO	N TRACE OF FISH	HERS LLC		RS, IN 46037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 63 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPL			ETED	
		155793	A. BUIL B. WIN			01/16/	2013
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HAMII TO	N TRACE OF FISH	HEBS LLC			CUMBERLAND RD RS, IN 46037		
TIAWILIC	IN TRACE OF FISH	IERO LLO		FISHER			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0216	410 IAC 16.2-5-2						
	Evaluation - None						
		d content of the evaluation ed in the facility policy					
		minimum the needs					
		include an evaluation of					
	the following:						
	(1) The resident '	s physical, cognitive, and					
	mental status.						
	(2) The resident 's independence in the activities of daily living.						
(3) The resident 's weight taken on admission and semiannually thereafter.(4) If applicable, the resident 's ability to							
self-administer medications.							
	(d) The evaluation	n shall be documented in					
	writing and kept in	n the facility.					
	Based on reco	rd review and	R02	16	R0216 I. The corrective		02/15/2013
	interview, the fa	acility failed to evaluate			actions to be accomplished	for	
	the ability of the	e residents to give			those residents found to hav	e ·	
	•	ir own medications.			been affected by the deficien		
	(Resident #550				practice. A self-administrati		
	(1.00.00111.11000	and " or i)			observation was completed or		
	Findings includ	۵:			1/11/13 for Resident #505 and #514 prior to survey being	1	
	i iliuliigs iliciuu	С.			conducted on 1/16/13.		
	4. Danamel massin	for Dooldont # 505			The facility will identify other	r	
		ew for Resident # 505			residents that may potentiall		
	•	on 1/16/13 at 9:00			be affected by the deficient	•	
		#505 was admitted on			practice. Resident's that		
	_	noses included, but			self-administer medications		
	were not limited	d to, hyperlipidemia,			residing in the facility had the		
	non insulin dial	petes mellitus, and			potential to be affected.		
	high blood pres	ssure.			The facility will put into place)	
					the following systematic		
	The computer	records were reviewed			changes to ensure that the deficient practice does not		
	•	505. The areas for			recur. Resident		
		ers, documents,			self-administration orders will	be	
		, observations, and			entered into the clinical record		
	events had a s				License nursing staff were		
	events nad a s	en medication	1		1		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 64 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	ILDING	00	COMPL	ETED
		155793	B. WIN			01/16/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	C			CUMBERLAND RD		
	ON TRACE OF FISH			FISHER	RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG			DATE
		ed 1/11/13. There were			re-educated on entering self-administration orders into	the	
		nedication evaluations			clinical record. IV The	u IC	
	found.				facility will monitor the		
					corrective action by		
	•	made to LPN #6, on			implementing the following		
	1/16/13 at 11:A	•			measures. DON or designe	ee	
	self-medication	n evaluations done on			will audit self-administration		
	Resident #505	upon admission on			orders monthly times 3 months then quarterly thereafter for a	S	
	12/29/11.				total of 12 months. Results	s of	
					this audit will be reviewed at the		
	In an interview	with LPN # 6 on			monthly Quality Assurance		
	1/16/13 at 3:15 P.M., she indicated				Committee meeting and		
	she could not f	•			frequency and duration of revi	ews	
		n evaluation than the			will be adjusted as needed.		
		/13 for Resident #505.			V. Plan of Correction completion date. Plan of		
					Completion date. Plan of Completion date is February 1	5	
					2013.	Ο,	
	2. The clinical	record for Resident					
		ewed on 1/16/13 at					
	10:10 A.M.						
	A physician's c	order, on 9/10/12,					
		esident "May keep and					
	dispense own						
	alopoi iso owii	modiodiono.					
	An evaluation	of the resident's ability					
	to self-adminis	-					
		as not found in the					
	electronic heal						
	electionic near	urrecord.					
	In an interview	on 1/16/13 at 2:15					
	•	ndicated she was					
		e any past evaluations					
		esident's ability to					
	administer her	own medications. She					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 65 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155793	A. BUILDING B. WING	00	COMPLETED 01/16/2013
	ROVIDER OR SUPPLIER		11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD	
	ON TRACE OF FISH		FISHEF	RS, IN 46037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	re-evaluations were able to acmedications.	ad recently completed of all residents who diminister their own the identified the Resident #514, and it /13.			

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 66 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	A. BUILDING 00 COMPLETED			ETED
		155793	B. WIN			01/16/	2013
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CUMBERLAND RD		
HAMILTO	N TRACE OF FISH	HERS LLC			RS, IN 46037		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0275	410 IAC 16.2-5-5	• •					
		onal Services - Deficiency					
	· ·	all be reviewed and revised					
		as the resident 's condition					
	requires.	ad and days are d	Dog				00/15/0010
	Based on record review and		R02	175			02/15/2013
	interview, the facility failed to ensure diet orders were provided so they				R0275		
		ved and updated by					
	physician as needed. (Resident #505, Resident #531, Resident #501)				I. The corrective actions t	•	
					be accomplished for those		
					residents found to have been affected by the		
	Findings includ	le:					
				_			
	1. Record review for Resident # 505				deficient practice.		
		on 1/16/13 at 9:00					
	•	#505 was admitted on					
		noses included, but			Diet order was entered in		
	_				clinical record for Resident		
		d to, hyperlipidemia,			#505, #531, and #501.		
		petes mellitus, and			#505, #551, and #501.		
	high blood pres	ssure.					
	The computer i	records were reviewed					
	•	505. The areas for					
		ers, documents,			II. The facility will identify	,	
	• •	, observations, and			other residents that may	'	
	. •				_		
	events had no	diet orders.			potentially be affected by		
					the deficient practice.		
	•	made to LPN #6, on					
		0 P.M., for the diet					
	orders from the				Resident's residing in the		
	Resident #505.				facility have the potential to	be	
					affected.		
	In an interview	with LPN # 6, on					
	1/16/13 at 3:15	P.M., she indicated					
		ind any diet orders					
		,	- 1		I		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 67 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155793	B. WIN			01/16/201	3
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF			11851 (CUMBERLAND RD		
	ON TRACE OF FISI	HERS LLC		FISHEF	RS, IN 46037		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ones dated 1/16/13 for					
Resident #505.				III The facility will put into	.		
					III The facility will put into	'	
	2. Record review for Resident # 531				place the following		
	was completed	d on 1/16/13 at 10:15			systematic changes to ensure that the deficient		
	A.M. Diagnoses included, but were						
	not limited to,	end stage renal disease		practice does not recur.			
	and dementia.						
	The computer	records were reviewed			Resident diet order will be		
	· •	531. The areas for			entered into clinical record		
physicians orders, documents,					upon admission.		
	progress notes, observations, and				'		
	events had no						
	CVCIII3 Had Ho	dict orders.					
	A request was	made to LDN #6 on			License nursing staff were		
		made to LPN #6, on			re-educated on entering die	et	
		00 P.M., for the diet			orders on admission.		
	orders from the						
	Resident #531						
	In an interview	with LPN # 6, on			IV The facility will monite	or	
		5 P.M., she indicated			the corrective action by		
		ind any diet orders			implementing the followin	g	
		ones dated 1/16/13, for			measures.		
	Resident #531	•					
	1769106111 #331						
					DON or designee will audit		
					diet orders monthly times 3		
					months then quarterly		
					thereafter for a total of 12		
					months.		
					Results of this audit will be		
					reviewed at the monthly		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 68 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155793		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/16/2013		
	PROVIDER OR SUPPLIE ON TRACE OF FIS		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				Quality Assurance Committed meeting and frequency and duration of reviews will be adjusted as needed.		
				V. Plan of Correction completion date.		
				Plan of Completion date is February 15, 2013.		
		record for Resident ewed on 1/16/13 at				
		om the physician was e electronic health				
	P.M., LPN #6 been a diet ord transfer form u	r, on 1/16/13 at 3:20 indicated there had der on the resident's upon admission in 2011, been transcribed into cal record.				

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 69 of 76

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (COMPLETED OAT 140 (2014)					
		155793	B. WIN			01/16/	2013
	ROVIDER OR SUPPLIER		•	11851 (ADDRESS, CITY, STATE, ZIP CODE CUMBERLAND RD RS, IN 46037	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0408	chest x-ray comp months prior to a Based on inter- review, the faci diagnostic ches six months prio 9 residents rev #514] Findings included The clinical recovas reviewed of A.M. The resident the facility 5/31 that included, by	- Noncompliance shall have a diagnostic leted no more than six (6) dmission. view and record ility failed to obtain a st x-ray no more than or to admission, for 1 of iewed. [Resident	R04	408	R0408 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice. Resident #514 has a current chest X-Ray showing no active disease.	e	02/15/2013
	electronic healt dated 8/26/11. A diagnostic ch within 6 months admission to the found. In an interview, P.M., LPN #6 in	y was located in the th record, but was nest x-ray completed s of the resident's ne facility was not on 1/16/13 at 2:15 ndicated she was not any other chest x-ray			II. The facility will identify other residents that may potentially be affected by the deficient practice. New residents admitting to AL community have the potential to be affected.		
	that would have 6 month time fr	e been done within the rame.					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 70 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155793	A. BUILDING	00	01/16/2013
		.007.00	B. WING	ADDRESS, CITY, STATE, ZIP CODE	3 11 13/23 10
NAME OF P	PROVIDER OR SUPPLIER			CUMBERLAND RD	
	ON TRACE OF FISH	HERS LLC		RS, IN 46037	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIFY THOU INFORMATION)	TAG	,	DATE
				III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.	0
				AL residents will have a diagnostic chest x-ray within months of the resident's admission to the community	
				Licensed nursing staff and Director of Marketing have been re-educated that ches x-rays must be completed within 6 months of admission to the community.	
				IV The facility will monitor the corrective action by implementing the followin measures.	g
				The DON/designee will aud new AL pre-admission paperwork 1 week prior to	III.

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 71 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2013 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155793	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED 01/16/2013		
		STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037				
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE		
			admission for 3 months a then quarterly thereafter total of 12 months.			
			Results of the reviews will presented at the monthly Quality Assurance Commeeting and frequency a duration of reviews will be adjusted as needed.	nittee and		
			V. Plan of Correction completion date.			
			Plan of Completion date February 15, 2013.	is		
	OF CORRECTION ROVIDER OR SUPPLIER ON TRACE OF FISH SUMMARY S' (EACH DEFICIEN	DF CORRECTION IDENTIFICATION NUMBER:	DF CORRECTION IDENTIFICATION NUMBER: 155793 ROVIDER OR SUPPLIER ON TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING B. WING STREET 11851 0 FISHER ID PREFIX	DEFORMED IDENTIFICATION NUMBER: 155793 ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER IN TRACE OF FISHERS LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) RESULTATORY OR LSC IDENTIFYING INFORMATION) REPOVIDERS PLAN OF CORRECTIVE (EACH ORRECTIVE ACTOR) SIGNATURE (EACH ORRECTI		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 72 of 76

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COI			COMPL	ETED	
155793		B. WING 01/16			2013			
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					CUMBERLAND RD			
HAMILTON TRACE OF FISHERS LLC			FISHERS, IN 46037					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					TE	COMPLETION	
TAG				TAG	DEFICIENCY)		DATE	
R0410	completed within admission or upo forty-eight (48) to The result shall be induration with the and by whom address of the first step is negated be performed with weeks after the firepeat testing will infection with tube (g) All residents we to the tuberculing to The Industry Industr	- Noncompliance tuberculin skin test shall be three (3) months prior to n admission and read at seventy-two (72) hours. e recorded in millimeters of e date given, date read, ministered and read. who have not had a ative tuberculin skin test preceding twelve (12) eline tuberculin skin testing e two-step method. If the ive, a second test should hin one (1) to three (3) rst test. The frequency of						
	review, the fact if a tuberculin stuberculosis has within three modern admission, or fuberculin skin for 2 of 9 reside (Resident #514). Findings include The clinical recovers was reviewed to	ailed to complete a test upon admission; ents reviewed. 1, Resident #538)	R04	-10	R0410 I. The corrective actions to be accomplished if those residents found to have been affected by the deficient practice. Resident #514 has current two step TB test completed. Resident #538 has been discharged. II. I facility will identify other residents that may potentially be affected by the deficient practice. Residents residing the AL community have the potential to be affected. Residents recent Tuberculin skin testing and updated as needed III. The facility will put into	e t t s a as Γhe y dent for	02/15/2013	

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 73 of 76

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) M		ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A.		A. BUILDING 00		COMPLETED	
155793		155793	B. WING			01/16/2013	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CUMBERLAND RD		
HAMILTON TRACE OF FISHERS LLC			FISHERS, IN 46037				
						T	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	1	5/31/12 from home, with			place the following systemat	ic	
	diagnoses that	included, but were not			changes to ensure that the		
	limited to, coug	gh, diabetes,			deficient practice does not recur. AL residents will hav		
	hypertension, and chronic pain.				an initial Tuberculin skin test u		
					admission per regulation.	Poli	
	A Nurse's Progress notes, dated 6/2/12, indicated the resident had arrived at 11:48 P.M. with her family;				Licensed nursing staff have be	en	
					re-educated on Tuberculin ski		
					testing guidelines. IV Th	e	
	and a note on 6/3/12, indicated she				facility will monitor the		
	had left early in the morning for a Leave of Absence with her family. A				corrective action by		
					implementing the following		
					measures. The DON or		
	note on 6/4/12, indicated the resident				designee will audit new AL admissions Tuberculin skin te	x	
	had been in the	e facility all day.			weekly for one month, monthly	• •	
					3 months and then quarterly		
	The electronic	health record e-MAR			thereafter for a total of 12		
	[electronic Med	dication Administration			months. Results of the revie	ews	
	Record] indica	ted a tuberculin skin			will be presented at the month	ly	
	test, although ordered upon admission, was not administered until				Quality Assurance Committee		
					meeting and frequency and		
	6/18/12.				duration of reviews will be		
	0.10.1=				adjusted as needed. V. Plan of Correction completion	n	
	In an interview on 1/16/13 at 2:15				date. Plan of Completion da		
		verified that the first			is February 15, 2013.		
					,,		
	step tuberculin						
		intil 6/18/12. She					
		vas unable to locate					
	documentation	of any other tuberculin					
	skin test prior t	to that one.					
	2. The record	for Resident #538 was					
	reviewed on 1/	16/13 at 11:30 a.m.					
	Diagnoses incl	uded, but were not					
	limited to, athle						
	· ·	·					
	hypertension a	ina aementia.					

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 74 of 76

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED			
155793		B. WING 01/16/2013						
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
					CUMBERLAND RD			
HAMILTON TRACE OF FISHERS LLC			FISHERS, IN 46037					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
TAG	A progress not 1:56 p.m., for Findicated, "Resapartment" An Electronic More for Resident #5 tuberculin skin on 6/2/12, and The record for documentation test was admin #538 prior to or facility. Documentation skin test for Resupon admission requested from Nurse [LPN] #6 p.m. During an inter 3:30 p.m., LPN record for Residocumentation tuberculin skin prior to or upon	e, dated 5/26/12 at Resident #538 sident checked into Medical Record [EMAR] 538 indicated a test was administered read on 6/4/12. Resident #538 lacked that a tuberculin skin histered to Resident r upon admission to the n of an initial tuberculin esident #538 prior to or n to the facility was n Licensed Practical 6 on 1/16/13 at 1 #6 indicated the dent #538 lacked		TAG	DEFICIENCY)		DATE	
	facility.							

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 75 of 76

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155793		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPI	COMPLETED 01/16/2013		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD								
HAMILTON TRACE OF FISHERS LLC			FISHERS, IN 46037					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

State Form Event ID: 70YU11 Facility ID: 012644 If continuation sheet Page 76 of 76